

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

Dr. J. Williams

-62-010497

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 428

FILED MAR 19 1962

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY GREENE | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY GREENE | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN SPRINGFIELD | | c. CITY OR TOWN SPRINGFIELD | |
| Length of stay in 1b 43 YRS. | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1005 ROANOKE | | d. STREET ADDRESS (If outside, give location) 1005 ROANOKE | |
| Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |

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| 3. NAME OF DECEASED (Type or print) First Middle Last FRED L. GRABER SR. | | | 4. DATE OF DEATH Month Day Year MARCH 14 1962 | | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 10/16/95 | 9. AGE (last birthday) 65 | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN | | 10b. KIND OF BUSINESS OR INDUSTRY HARDWARE | | 11. BIRTHPLACE (City and state or country) ST. LOUIS, MO. | |
| 12. CITIZEN OF WHAT COUNTRY USA | | | | | |

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|--|--|--|--|---|--|
| 13a. FATHER'S NAME HENRY H. GRABER | | 13b. MOTHER'S MAIDEN NAME MARY DEMOORE | | 14. NAME OF HUSBAND OR WIFE FRIEDA M. GRABER | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES W.W. # 1 | | 16. SOCIAL SECURITY NO. 2 | | 17. INFORMANT Address FRIEDA GRABER, SPRINGFIELD, MO. | |

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| 18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis | | INTERVAL BETWEEN ONSET AND DEATH 7 |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ | | |

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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Elec. Shock therapy 1961 | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | |
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|---|---|--|--------------|
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) | |
| 20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year | | | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 20f. CITY, TOWN, OR LOCATION | COUNTY STATE |
| 21. I attended the deceased from 3/14/62 to 3/14/62 and last saw him alive on 4-10-61 Death occurred at 8:35 A.M. on the date stated above, and to the best of my knowledge, from the causes stated. | | | |

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| 22a. SIGNATURE (Degree or title) John Williams M.D. | | 22b. ADDRESS Springfield, Mo. | | 22c. DATE SIGNED 3/14/62 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b. DATE 3/17/62 | 23c. NAME OF CEMETERY OR CREMATORY ST. MARY'S CEMETERY | | 23d. LOCATION (City, town, or county) SPRINGFIELD, MO. |
| 24. FUNERAL DIRECTOR ADDRESS H. H. LOHMEYER FUNERAL HOME | | 25. DATE RECD. BY LOCAL REG. 3-15-62 | | 26. REGISTRAR'S SIGNATURE Effie S. Patton |

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

INSTEAD OF

DATE AMENDED

BY AFFIDAVIT OF

DOCUMENT

MEDICAL CERTIFICATION

VS 300
Rev. 4/59

1 **0397**
2 **0397**
3
4 **0**
5 **1**
6
7 **0**
8 **0**
9 **332X**
10
11
12 **90-0**
13

MAR 23 1962
MAR 27 1962

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *W. H. McCall*

Licensed Embalmer No. 2727

P. O. Address *[Signature]*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.

Permit renewed 3-15-62